Department of Health Care Services
Substance Use Disorder Compliance Division
Sacramento, CA 95811-4037

DRUG MEDI-CAL APPLICATION

(Substance Abuse Clinics)

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

SUBSTANCE USE DISORDER COMPLIANCE DIVISION
Licensing and Certification Branch, MS 2600
PO Box 997413
SACRAMENTO, CA 95899-7413

(916) 322-2911
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DRUG MEDI-CAL APPLICATION INSTRUCTIONS

This application package contains the materials necessary to apply for Medi-Cal program participation as a substance abuse clinic as well as to submit information regarding changes in clinic information with the Department of Health Care Services (DHCS).

It is vital that you carefully read each component within this application.

Substance abuse clinics are certified for Medi-Cal program participation by the Department of Health Care Services (DHCS). To apply for certification, complete pages 1-4 of the attached application and submit the completed application to:

Department of Health Care Services
Licensing and Certification Branch, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

The Medi-Cal certification requirements for substance abuse clinics are contained in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics, effective July 1, 2004; the Standards for Drug Treatment Programs; and Title 22, California Code of Regulations Sections 51341.1, 51490.1, and 51516.1, which are available online at www.dhcs.ca.gov/services/adp/pages/drug_medical.aspx. Reading each of these documents before completing an application is important.

In addition to completing the attached application and supplying the DHCS with the required supportive documentation, applicants must also complete and submit the Medi-Cal Disclosure Statement (form DHS 6207), available at www.dhcs.ca.gov/services/adp/documents/03enrollment_DHCS6207.pdf at the time of application.

Listed below are specific instructions for completing the application for different types of Drug Medi-Cal (DMC) certification activities. All applicable portions of the application must be fully and accurately completed with current information. Supportive documents must accompany the application. Retain a copy for your records. **For all types of applications, the signature of an authorized official, including a copy of the individual's authorization to sign, is required.**

Original Application

A substance abuse clinic or satellite site applying for initial DMC certification must complete all sections of the four-page application and supply all required documentation. If a section is not applicable, please enter the notation N/A in the space provided. In addition, a Medi-Cal Disclosure Statement (DHS form 6207) must accompany the application.

Additional Services

A substance abuse clinic or satellite site applying for additional services must complete Items I, II, V, VI, VII, VIII (for each additional service), IX (if applicable), X, XII, XIV, and any other Items necessary to report a change in information.

Adding Satellite Site

A substance abuse clinic adding a satellite site clinic (which is defined as providing treatment abuse services 20 hours or less per week) must complete Items I, II, V, VI, VII, X, XI, XII, XIII (if applicable), and XIV.

Relocation or Expansion

A substance abuse clinic or satellite site that is moving or expanding must complete Items I, II, V, VI, VII, IX (if applicable), X, XI, XII, XIV, and any other Items necessary to report a change in information.

Note: The Drug Medi-Cal Certification Standards for Substance Abuse Clinics, effective July 1, 2004 require at least 60 days' notice prior to relocation of a parent or satellite site. Failure to provide 60 days advance notification or complete documentation may result in suspension from participation in the Medi-Cal program. **Services provided at the new location shall not be DMC reimbursable until certification of the new site has been completed by DHCS. Payment for services rendered at an uncertified site will be recovered by DHCS.**

Change of Ownership

A substance abuse clinic applying for a change of ownership must complete all sections of the four-page application and supply all required documentation. In addition, a Medi-Cal Disclosure Statement (form DHS 6207) must accompany the application.

Upon completion of the application, attach a cover letter describing your request. Include any additional information that would be helpful to the Department in processing your application. Be sure that the application is signed on the final page, supply all required documentation, and return the application to the Department of Health Care Services (DHCS). It is important to note that substance abuse clinics cannot be reimbursed under the DMC program until the new clinic, service, location, or ownership has been certified. The certification process usually includes an on-site review.

The following instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions are given to questions considered self-explanatory. These instructions apply to clinics and satellite sites.

Item I. Indicate the name and address of the legal entity in control of the clinic. If a corporation, indicate the name as it appears on the Articles of Incorporation. If a partnership, the name as it appears on the partnership agreement. If a county, indicate the name as it appears on the county charter. Include the four-digit Drug Medi-Cal Provider number if previously assigned, i.e., if a provider is applying for additional services, to add a satellite site, or for relocation.

Insert the 6-digit number under which the program reports participant information, i.e., California Alcohol and Drug Program Data System (CAADS) number.

Include the 10-digit National Provider Identifier (NPI) used to identify health care providers on Health Insurance Portability and Accountability Act (HIPAA) covered transactions. If the provider does not have a NPI, contact the entity that will be assigning the NPI (the Enumerator) at (800) 465-3203 or https://nppes.cms.hhs.gov.

Indicate to what mailing address mail, e.g., the compliance report, Certification and Transmittal, Department notifications regarding the DMC program, etc. should be sent.

Item II. Include the name of the clinic director (the individual responsible for the day-to-day operation of the clinic) and the executive director (the individual responsible for representing the legal entity in the operation of the clinic).

Item III. Identify the type of legal entity in control of the clinic and attach the requested documentation. For a corporation, attach a copy of the Articles (as filed with and endorsed or stamped by the Secretary of State). For a partnership, attach a copy of the partnership agreement.

Item V. If the DMC program operates at the same location as a program providing another type of services, e.g., driving under the influence or certified alcohol and/or other drug program, and only the DMC certified program is relocating, indicate this information. Or if only a portion of the services provided at the DMC clinic are relocating, indicate this information. Or indicate the relocation of the entire program.

Item VI. Enter **all** services to be provided by the DMC clinic, including existing services and additional services being requested.

A Narcotic Treatment Program (NTP) license from DHCS is required to provide NTP services.

Item IX. A residential alcoholism or drug abuse recovery or treatment facility license from DHCS is required to provide adult perinatal residential substance abuse services. The facility must have a maximum treatment capacity of 16 beds or less. Beds occupied by children who stay in the facility with their mothers are not counted in the 16-bed limit.

If the site is licensed as a community care facility by the Department of Social Services (DSS), attach a written waiver from the DSS District Office to allow the use of a portion of the facility or grounds for nonlicensed service activities. Contact your DSS District Office for the requirements and procedures.

Note – the Department of Health Services licenses primary care clinics. Refer to Health and Safety Code Section 1201 regarding the licensure requirements for these clinics.

Item XI. Attach a copy of a current fire clearance for an inspection that has been conducted within the previous 12 months and that clearly identifies the clinic by name and address. A fire clearance is not required if the clinic is located entirely on public school grounds. A letter from the principal authorizing the provision of services and certifying that all locations where services are provided meet fire safety rules and regulations is sufficient.

Item XII. Local zoning approval is required for all clinics except:
1) Those located entirely on public school grounds, and
2) Those operated in a building that is owned or leased by a public entity. For a clinic located entirely on public school grounds, attach a letter from the principal authorizing the provision of services on public school grounds. For a clinic operated in a building that is owned or leased by a public entity, local zoning approval is not required. A letter stating that this is the case is sufficient.

Item XIII. An office-based opiate treatment program (OBOT) is required to be either 1) licensed by DHCS, or 2) affiliated with a licensed NTP treatment program or licensed OBOT. A medication unit is required to be affiliated with a licensed NTP treatment program. Attach proof of affiliation.

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Drug Medi-Cal Application
(Substance Abuse Clinics)

This form must be completed for each site desiring to participate in the Drug Medi-Cal program.
See the General and Specific Instructions for instructions on completing this application.

<table>
<tr><td rowspan="8">I.

Identifying Information for Substance Abuse Clinic</td><td>Legal Entity Name (for entity in control of clinic or satellite site)</td><td>4-digit Drug Medi-Cal Provider Number, if assigned:</td></tr>
<tr><td>Program/Clinic Name</td><td rowspan="2">Do you have a 6-digit number under which you report client information?
No ☐ Yes ☐, write number below:</td></tr>
<tr><td>Street Address (where services will be provided)</td></tr>
<tr><td>City, State, Zip Code</td><td>Program Telephone Number:
( )</td></tr>
<tr><td>Mailing Address</td><td>Type of location (clinic, doctor’s office, residential facility, etc.)</td></tr>
<tr><td>City, State, Zip Code</td><td>10-digit National Provider Identifier (NPI)</td></tr>
<tr><td>If clinic site is leased or rented, full name and address of owner
(Include a copy of the lease/rental agreement or verification from the space owner, if the space is donated at no cost)</td><td>Federal Employer Identification Number (FEIN):</td></tr>
<tr><td></td><td>County of program operation</td></tr>
<tr><td>II.

Administration</td><td colspan="2">Clinic Director: _____
Telephone Number: ( ) _____</td></tr>
<tr><td></td><td colspan="2">Executive Director: _____
Telephone Number: ( ) _____
Email Address: _____</td></tr>
<tr><td>III.

Type of Agency or Entity in Control of Clinic</td><td colspan="2">Check one and complete or attach additional information for legal entity:
☐ Sole proprietorship
☐ Partnership (Attach copy of partnership agreement)
☐ Not for profit corporation (Attach copy of Articles of Incorporation)
☐ Other corporation (Attach copy of Articles of Incorporation)
☐ Government entity
☐ Other</td></tr>
<tr><td>IV.</td><td colspan="2">Identify the sources of funds and income for operations (i.e. client fees, third party payers [insurance companies, employee health plans] county funds, state funds [include department and fund source, if known] other public funds, etc.)</td></tr>
</table>

Funding Sources	
V. **Type of Application**	Check all that apply ☐ Original Application ☐ Adding Satellite Site (20 hours or less of service per week) ☐ Additional Services ☐ Relocation, From: _____ Effective Date: _____ Is this a relocation of the entire program ☐ or only the Drug Medi-Cal component ☐ ? ☐ Change of ownership, From: _____ ☐ Other, please specify: _____
VI. **Service Modality(ies)**	Identify the service modality (ies) and treatment component (non-perinatal or perinatal) requested for the site. If the site is currently certified, include service modality (ies) and treatment component(s) that the provider wishes to continue as well as those to be added. Type of site — Current and/or requested service modality (ies) Narcotic Treatment Program (NTP) — Non-perinatal ☐ Perinatal ☐ Narcotic Treatment Program (NTP) — Non-perinatal ☐ Perinatal ☐ Day Care Rehabilitative (DCR) — Non-perinatal ☐ Perinatal ☐ Outpatient Drug Free (ODF) — Non-perinatal ☐ Perinatal ☐ Naltrexone — Non-perinatal ☐ Perinatal Residential — Perinatal ☐
VII. **Hours of Service Provision**	☐ More than 20 hours per week (substance abuse clinic) ☐ 20 hours a week or less (satellite site)
VIII. **Drug Protocol**	☐ Attached is a drug protocol for each service modality being requested (narcotic treatment program, day care rehabilitative, perinatal residential, naltrexone, outpatient drug free)

IX. **For Perinatal Residential Substance Abuse Applicants Only**	Is the facility separately licensed by the DHCS? Yes ☐ No ☐ Number of treatment beds: _____ **NOTE: A Perinatal Residential Program cannot have more than 16 treatment beds.**
	Are all food, shelter, and alcohol or drug recovery or treatment services provided at the licensed facility? Yes ☐ No ☐ If no, what services are provided on site, what services are provided offsite, who provides the services and at what address are the services provided?

IX. **For Perinatal Residential Substance Abuse Applicants Only**	Are any foods, shelter, or alcohol or drug abuse recovery or treatment services provided at the facility for another licensed residential facility? Yes ☐ No ☐ If yes, list what services are provided and the name and address of the facility for which these services are provided.
X. **Staff**	All programs must designate a medical director and a clinic director. Personnel files must match information on application. List the staff that will provide direct treatment services at this location. Include staff under contract. Attach a separate piece of paper if necessary. ***Name*** ***Function*** _____ Medical Director ☐ Attached is a copy of the Medical Director's current license from the Medical Board of California. _____ Clinic Director _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ ☐ For an office based opiate treatment program (OBOT) satellite site, a copy of the physician or pharmacy license is attached. Pursuant to the CCR, Title 9, Division 4, Chapter 8, Section 13010 at least thirty percent (30%) of staff providing counseling services in all AOD programs licensed and/or certified by DHCS shall be licensed or certified pursuant to the requirements of this chapter. All other counseling staff shall be registered pursuant to Section 13035 (f). Licensed professionals may include LCSW, MFT, Licensed Psychologist, Physician, or registered Intern, as specified in Section 13015.
XI. **Fire Clearance**	☐ Attached is a valid fire clearance from the local authority assuring that all fire safety requirements have been met and issued no more than 12 months prior to the date of this application. ☐ The site is located entirely on public school grounds. Attached is a letter from the school principal certifying that all locations where substance abuse services are provided meet fire safety rules and regulations.

XII. **Local Zoning Approval**	Check one of the following that applies to the site: ☐ Attached is documentation of local zoning approval for the site and services requested. ☐ The site is located entirely on public school grounds. Attached is a letter from the school principal authorizing the provision of services. ☐ The site is located entirely within a building that is owned or leased by a city, county, or state and is exempt from zoning approval requirements. ☐ The site is not required to obtain local zoning approval. Attached is a letter from the local agency responsible for issuing zoning approval stating that zoning approval is not required.
XIII. **Narcotic Program Affiliation**	For a medication unit or a satellite OBOT: ☐ Attached is proof of affiliation with a licensed Narcotic Treatment Program or affiliation with a licensed OBOT.
XIV. **For Individual Signing the Application**	If the applicant is a sole proprietorship, the application shall be signed by the sole proprietor; if a partnership, by each partner; or if a firm, association, corporation, or government entity, by the chief executive officer or individual legally responsible for representing the entity. ☐ Attached is a copy of the resolution or Board minutes authorizing the individual to sign. ☐ Attached is a copy of the individual's Social Security Card. _____ Date of Birth

I certify that the legal entity/provider applying to participate in the Drug Medi-Cal program is not barred from certification under Section 14043.36 of the Welfare and Institutions Code and that the information contained in this application and supporting documentation is true and correct.

The applicant understands they must comply with all requirements established in Title 22, California Code of Regulations, Division 3, Chapter 3, Article 4, Section 51341.1; the Drug Medical Certification Standards for Drug Treatment Programs; and have all records, documents, policies, and procedures immediately available upon request during an onsite inspection. It is the responsibility of the applicant to ensure that its systems, programs, policies, processes, and related activities comply with all aforementioned requirements.

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of authorized official | Title | Name (Typed or Printed) | Date